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ISSUE BRIEF

Medicaid's Role in Financing Services for AIDS Patients

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INTRODUCTION

Providing health care services to AIDS patients is of increasing concern as the public policy response to AIDS continues to develop. Much of the attention to the AIDS issue thus far has focused on education, prevention, testing, and research. Only recently have questions concerning coverage and financing of services for AIDS patients begun to receive substantial notice. A Congressional hearing was held to discuss cost-effective options for treatment. The Robert Wood Johnson Foundation initiated a program to promote service coordination in metropolitan areas with heavy caseloads. In addition, several states, in conjunction with efforts of governors' task forces on AIDS, are assembling information about service costs and delivery alternatives. Although the incidence of AIDS cases varies greatly among states, these issues merit general concern because of the uncertainty about the impact over time.

At the beginning of March 1986, over 17,000 AIDS cases had been reported to the Center for Disease Control (CDC). Epidemiological analysis predicts that the number of cases will continue to double, or nearly double, each year. In addition, the number of AIDS-related complex (ARC) cases is increasing rapidly; although less serious than AIDS, this illness can also produce debilitating symptoms. To date, neither a cure nor a vaccine has been discovered for AIDS, and the disease seems to be fatal in all cases. The treatment available for AIDS patients involves highly specialized care, both in and out of the hospital, and the services needed to treat their symptoms tend to be costly. As the number of cases increases, the financing of medical services will place corresponding increased demands on both providers and purchasers of care.

For a variety of reasons, it is difficult to determine precisely who pays for the total costs of care for AIDS patients. As with other aspects of AIDS, the financing issue is characterized by what is not known, rather than what is known. There are a number of unanswered questions about how much services cost and who pays these costs. Available data are limited because the disease

is new and because patient confidentiality is an important concern. It seems reasonably clear, however, that public funding sources are making a sizable contribution to the total costs. Current federal estimates state that 40% of AIDS patients are being served under Medicaid at any one time; only one percent are under Medicare.* At the state and local level, there are a variety of programs. Low income, unmarried men, a category in which a number of AIDS patients fall, are frequently eligible for state general assistance programs. In addition, some states and metropolitan areas where AIDS is a particular problem are designing programs specifically for AIDS patients, often in co- operation with community advocacy groups.

In general, the following discussion examines issues of providing and financing care of AIDS patients, with the focus on the Medicaid program. Policies are bound to vary widely among the states, since the incidence of AIDS cases varies significantly. Every state has had at least one reported case, but the majority have been concentrated in New York, California, Florida, New Jersey, and Texas.

Although complete data are unavailable and conclusions are therefore tentative, a number of key points emerge:

- Care for AIDS patients is paid for primarily by private health insurance and Medicaid. It is unclear whether there is significant shifting of patients from private insurance to Medicaid, as patients exhaust their resources and the limits of private coverage.

- A person diagnosed with AIDS is presumed to be disabled for purposes of eligibility for the federal Supplemental Security Income (SSI) program. If the patient meets financial eligibility requirements, he or she is eligible for SSI benefits and Medicaid coverage. A number of patients may also be Medicaid eligible prior to diagnosis of AIDS.

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* Smith, Elmer W., Health Care Financing Administration. 1986. Statement before the Subcommittee on Health and the Environment, Committee on Energy and Commerce, U.S. House of Representatives, March 5, 1986.

- Total Medicaid expenditures are difficult to determine, since program records do not always indicate AIDS as the diagnosis, for reasons related to confidentiality and to imprecise diagnostic codes. From limited information, the Health Care Financing Administration

  estimates that $50 million in federal Medicaid funds were expended during 1985 for care to AIDS victims and that in fiscal year 1986, $100 million will be spent with similar amounts in state and local funds also spent for AIDS patients.

- AIDS victims seem to spend more time than necessary in the high cost, inpatient hospital setting. Programs offering a mix of medical and social services in the home and community, often under the direction of case managers, provide care which is both cost-effective and compassionate.

- Depending on the number of cases involved, state Medicaid programs can serve eligible AIDS patients within the existing program structure, but also can choose to modify existing features such as reimbursement rates or perhaps to develop alternative delivery systems through federal waiver authority.

- Any option a state might choose is effective only with adequate provider participation. Nursing homes and home health agencies, however, often hesitate to treat AIDS patients.

The remainder of this paper elaborates these points and attempts to provide a framework for questions about Medicaid's role in care which is both cost-effective and appropriate to the needs of AIDS patients.

Range of Payment Sources

A person suffering from AIDS may be able to pay for needed services through a series of payment sources beginning with private insurance, perhaps moving to private pay, and finally turning to Medicaid or another public

assistance program. Anne Scitovsky of the Palo Alto Medical Foundation cites the following statistics on payment sources for 826 cases between January and June 1985, in San Francisco's West Bay Hospital Conference:

Percent of Cases by Payment Source

	Medi-Cal (Medicaid)	Private Insurance	Medicare	Other
All Cases	30.5%	43.3%	2.6%	23.6%
San Francisco General (Public Hospital)	62.4%	16.9%	2.8%	17.9%
HMO (Kaiser)		100%		
Other Hospitals	16.3%	70.5%	3.0%	10.5%

Scitovsky cites similar figures for New York City during 1984, with 42.3% of cases paid for by Medicaid, 41.8% of cases by commercial insurance, and 15.9% by other payers. Since statistics show distribution among payment sources for a given period, they do not reveal any possible patterns of changes in the payment services to which individuals turn (e.g., private to public) over time.

In Massachusetts, a study of 41 cases of AIDS or ARC from March 1984 through March 1985 in one hospital yielded coverage and cost information as follows: 51% of the cases had Blue Cross coverage, 20% were covered by Medicaid, 15% had no coverage; and, the remainder were covered by commercial health insurers. The monthly average expenditure per case was $4,876 for Blue Cross enrollees and $2,121 for Medicaid recipients.*

When considering cost of care, one hidden issue is the potential for shifting of patients among payers as the illness progresses and bills mount. The Medicaid program, as payer of last resort in many cases, is in a position to experience the impact of increasing AIDS cases and accompanying costs.

* Telephone conversation with George Seage, MPH, AIDS Epidemiologist, Boston Department of Health and Hospitals.

Data which track and compare individual courses of illness and treatment, from the point of view of financing the treatment, are uncommon. The severity of the illness varies over time, and costs are bound to follow a corresponding pattern. AIDS patients appear to have two periods of peak cost: one at the time of onset or initial diagnosis, the other just prior to death. If costs for the first period are covered by other payers, by the time the patient qualifies for Medicaid, the major remaining expenditures may include little more than the final hospitalization. However, the analysis would be different and the Medicaid cost estimates higher in instances where the patient becomes eligible for Medicaid near the onset of the illness.

Features of different high risk populations in different parts of the country may also account for hidden variations in costs among payment sources. For instance, drug addicts concentrated in some urban areas are perhaps less likely than some middle class homosexuals to begin with private insurance and more likely to rely heavily on public funding throughout the illness.

Medicaid Eligibility

In order to become eligible for Medicaid, there are specific criteria which the patient must meet. Any person with a diagnosis of AIDS is presumed to be disabled for purposes of SSI (Supplemental Security Income) eligibility, as a result of a 1983 directive by the Social Security Administration's Office of Disability Programs. In most states if a patient meets the income and resource standards or the disability definition for SSI, he or she can qualify for this program and hence for Medicaid within a shortened eligibility determination period though some states, however, apply more stringent income, resource, or disability requirements. Patients who do not qualify immediately for cash assistance may meet financial eligibility criteria after depleting their resources to pay for services. Others may eventually lose private coverage when they are no longer able to work, nor to afford individual insurance. Those who remain covered by private insurance may be affected by some insurers' attempts to exclude coverage for AIDS.

Theoretically, given enough time, every AIDS patient could exhaust resources to a level where medical expenses would become the responsibility of Medicaid. For a variety of reasons, this is a highly unlikely scenario. As with any other disability determination, the patient must still meet SSI and

Medicaid income and resource standards. Although the deter- mination process is shortened by presumption of eligibility, the disease may progress too quickly for many patients to exhaust their own resources and then complete application processes, even shortened ones, for SSI and Medicaid.

On the other hand, some relevant evidence suggests that members of the IV drug-user risk group and their sexual partners also at risk may be more likely to be low income and therefore eligible for Medicaid or other public funding when they become ill, or shortly afterwards. The impact on Medicaid could be considerable in areas where this risk group is concentrated. The significance of this group may grow as heterosexual transmittal becomes more frequent, resulting in more illness among low-income women and children born to infected women.

Medicaid Expenditures for AIDS

Firm data on the numbers of Medicaid eligibles with AIDS and the costs incurred by Medicaid programs are difficult to obtain. Although nearly every state requires reporting of identified AIDS cases to some central clearinghouse, this information may not always be available to the Medicaid agency. A patient's right to confidentiality is a primary concern, and in some states, release is prohibited by law. Identifying AIDS cases in the Medicaid program's own records is hampered by the lack of a distinct diagnostic code. Finally, a firm diagnosis of AIDS may not occur until some time after the onset of symptoms; this was especially true before the HTLV-III test became available.

When a diagnosis of AIDS does occur, providers are often uncertain about which category to use for diagnosis and billing. Since there are currently no specific DRG categories for AIDS and ARC, a provider might assign a patient to a category corresponding to a fee which is considerably lower or considerably higher than the actual costs incurred. Clarification could conceivably result in some adjustment of cost estimates for AIDS recipients in the long run. Assigning specific codes to AIDS might be perceived as an attempt to track or label AIDS patients and potentially violate their rights to confidentiality. This con- sideration contributes to the difficulty in measuring expenditures for the care of Medicaid eligible AIDS patients.

Two states which have been able to collect limited data on Medicaid expenditures for very small samples of AIDS patients are Michigan and Maryland. In Michigan, thirty-one death certificates of known AIDS patients were obtained and compared with eligibility files. Fourteen individuals matched both files, and relevant data was available for ten of these. For these ten, the average per patient cost to Medicaid was $52,230.00 with an average period of twenty months of eligibility. The range for these figures was from $2,525.86 to $90,305.03 for costs and from five to thirty-six months for length of eligibility. Some of these beneficiaries were also receiving general assistance funds.

Maryland's data, obtained from a study of the state's first 88 cases, Medicaid and otherwise, showed 30% or twenty-eight of these becoming Medicaid eligible some time during the course of the illness. Since not all patients were deceased at the time of this study, more of the 88 cases may have become eligible later. However, the available information yielded average costs to Medicaid of between $13,921.96 and $18,834.99 per patient with an average duration of eligibility of about nine months. Again a significant number of these patients began in state-funded categories such as general assistance before being certified as eligible for federal funding through the SSI program.

Both of these studies, in Michigan and Maryland, repeatedly stress the preliminary nature of the data. The differences in the finding serve to affirm general reluctance to draw conclusions about the cost of AIDS for Medicaid. In addition to small sample size, any number of factors, several cited earlier, might help account for wide variations in findings.

The most extensive study of the cost of Medicaid services for AIDS patients has been undertaken by the California Department of Health Services.* Based on data developed by comparing the list of AIDS patients to Medi-Cal eligibility files, the study estimated that twelve percent (404 persons) of AIDS patients were eligible for Medi-Cal.

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* A Quantitative Analysis of AIDS in California. California Department of Health Services. March 1986.

Examination of the claims history for each Medi-Cal AIDS patients yielded the following service utilization and expenditure data. Medi-Cal expenditures totalled $4.5 million in FY 1984-85 and is projected to increase by 136% to $10.6 million in FY 1985-86. The average cost per patient was $59,000 basedon 18 months of life expectancy from the diagnosis. Costs are highest during the first four months following diagnosis, about $7,500 per month, and the three months before death, about $6,500 per month. Hospital costs comprise the bulk of expenditures, 91 percent due to the average frequency of admission, once every 3 months, and the average length of stay, 14 days.

An additional element which could underlie differences among cost estimates across the country is the variation in population concentrations of the two primary risk groups, IV drug users and male homosexuals/bisexuals. Research suggests that there may be links between risk categories and the opportunistic infections to which their members are prey. The severity of symptoms and the care needs of various AIDS and ARC related illnesses may thus be related to features of local populations. IV drug users appear to be more susceptible to pneumocystis carinii pneumonia whereas male homosexuals/ bisexuals appear to be more susceptible to Kaposi's sarcoma. The latter is often less severe and less expensive to treat while the former frequently requires more costly inpatient care. On the other hand, the milder symptoms might permit costs to accumulate over a longer lifespan. Such factors, if significant, could influence the timing of eligibility determination and resulting expenditures in different states and different parts of the country.

Another factor that affects a states ability to estimate coverage and expenditures both now and in the future is AIDS patient migration between states. The CDC reports AIDS cases in the state where the case is diagnosed. However, the reported state may not be the state where the AIDS patients resides nor the state where the AIDS patient receives services. For example, persons who suspect they have contracted AIDS may, for reason of confidentiality, travel to another state to be tested. Also, persons who have been diagnosed with AIDS in one state may move to another state where specialized treatment is available or move to be with family. To the extent that migration between states occurs, states may find that their AIDS caseloads and expenditures vary considerably from the CDC list of reported cases.

For example, during the past year New Mexico AIDS Services provided services to 38 persons with AIDS, only 18 of which were diagnosed in New Mexico.* California estimates that due to the migration phenomenon, the number of AIDS cases in California is understated by about two percent.

Coverage and Service Needs

For both Medicaid and the medical community as a whole, a crucial component of the potential cost burden which may be possible to control is the cost per case. The first CDC estimates indicated a figure of approximately $140,000 as an average per patient cost, while more recent estimates have been considerably lower. There are a number of plausible explanations for wide variations in cost and adjustments to early estimates. When the disease first began to appear, lack of clinical experience with treating the various symptoms may have been responsible for unnecessarily high expenditures, as physicians tried different treatments and kept patients hospitalized for long periods. As experience and understanding grow, treatment methods and costs may be stabilizing at a lower figure than initial estimates suggested.

In areas such as San Francisco, where the medical community has acquired considerable experience with AIDS patients, diverse care networks have developed with the help of hospitals, particularly San Francisco General, and community support groups. In addition to specialized inpatient care, community based services, outpatient clinics, hospice care, home health and case management services are available. The presence of such a network may account for San Francisco General's relatively low per patient cost estimates of $25,000 to $32,000.

Hoping to encourage the development of other networks based on the San Francisco model, the Robert Wood Johnson Foundation has decided to make available $17.2 million in grants to groups in the 21 U.S. cities with the largest AIDS caseloads. The Foundation will award only one grant in each metropolitan

* Letter. Kathleen Valdez, Human Services Department, State of New Mexico. March 26, 1986.

area in an attempt to promote citywide coordination of services through programs to include AIDS-specific ambulatory services as well as case management, nursing, hospice, and other support services. These grants, to be awarded by October 1986, may help to provide additional models for comprehensive care.

An approach on the same scale may not be cost-effective or practical in localities where patient concentrations are not as high and where individual hospitals serve small numbers of AIDS patients. However, even without care networks like that in San Francisco, nursing homes, hospices, or other forms of community-based care may be viable, lower cost alternatives to lengthy hospital stays. Perhaps the development of some sort of case management approach in this context might help meet the needs of not only AIDS patients but also other terminally ill patients.

State Medicaid programs cover services to eligible AIDS patients the same way they would for victims of any other disease; in general, Medicaid cannot discriminate by diagnosis nor tailor coverage to particular illnesses under the regular on-going program. An increasing number of AIDS cases will almost certainly lead to an increasing cost burden and need for adequate services. For Medicaid, already under fiscal pressures, there is considerable incentive to used cost-effective ways to provide care. Under the Medicaid program a broad range of home and community-based services can, at the option of the state, be made available to recipients. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) has authorized as optional services both case management and hospice services as items that states can choose to provide under their regular Medicaid program.

Outside the Medicaid program some states have begun to develop special programs for AIDS patients, involving case management, social services, and expanded home health care. While the basic aim of these programs is to provide humane treatment, they also appear to be more be more cost-effective than the ordinary delivery system. The work of the San Francisco network supports this contention, although other circumstances may also be at work there.

The New York State Department of Health, through its AIDS Institute, is in the process of establishing a number of comprehensive AIDS care centers where

all levels of care and services, both inpatient and outpatient, will be arranged for or provided. Case managers will also follow up and monitor effectiveness of services. Michigan, with a smaller number of cases, is also considering developing an expert tertiary care program for treatment in the Detroit area, as well as a small residential facility, a network of community-based hospitals, and one or more dedicated long term care units.

Options for Delivery Systems

Medicaid rules do not readily accommodate programs designed for specific diseases or conditions. Federal regulations prohibit expanded benefits for recipients with a particular diagnosis under the regular ongoing Medicaid program. These rules have been rigorously enforced by both HCFA and the courts. This means that a Medicaid agency cannot create special services for AIDS patients only. Nevertheless, Medicaid recipients with AIDS appear to have encountered some of the same access problems as other beneficiaries. Their care has been fragmented and episodic, often centered in outpatient departments or emergency rooms. Their hospital stays are prolonged because the services that would allow them to return to their homes or other community settings are unavailable. A spot check of AIDS patients receiving Medicaid in New Jersey hospitals in October 1985 found that 25% of these could be discharged and placed in nursing homes or offered some other lower level of care.

An agency might respond to these problems by creating general programs for the terminally ill (this would amount to a permissible level of care distinction, rather than a diagnostic one). Medicaid agencies have had difficulty meeting the needs, not only of AIDS patients, but of cancer victims and other recipients whose needs might be better met outside the inpatient setting. The options under discussion might, then, be regarded as possible approaches for all terminally ill patients.

One promising approach is some form of hospice arrangement to help the terminally ill patient remain at home. This kind of care, which combines home health care and social services with occasional short-term inpatient treatment, has been funded by Medicare on an experimental basis since 1982. States can now choose to provide hospice services under their Medicaid programs as a

result of recent statutory amendments. For instance a state might offer a cluster of services including physician visits, home health, and personal care which might resemble a hospice package or choose to offer hospice services themselves.

The recent passage of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA; HR 3128) contains a number of provisions that could be useful for improving services to AIDS patients who are Medicaid recipients. First, COBRA allows states to provide hospice care as an optional service in their Medicaid plans. Hospice care under Medicaid would have to adhere closely to the hospice benefit under Medicare including; conditions of participation, and reimbursement rates. Hospice coverage could not be restricted solely to AIDS patients, but coverage is limited to terminally ill individuals, which could include AIDS patients.

The COBRA also added case management as an optional Medicaid service. The Act allows states to target case management to geographic areas within the state and would not have to be offered to all Medicaid recipients. While case management could not be limited to AIDS patients only, there is an opportunity for states to include AIDS patients as recipients of case management.

Another tactic which states have used for tailoring service packages to meet the needs of specific populations is the development of waiver programs. To date, no state has applied to HCFA for a waiver which would include services for AIDs patients, although some states have made informal inquiries.

Home and Community Based Services Waivers

HCFA has indicated that waivers can be granted to provide home and community based services (2176 waivers) to individuals with AIDS, provided that all the statutory and regulatory requirements are met.

In general, Section 2176 waivers are intended to permit states to target cost- effective community based services to Medicaid recipients who might otherwise be institutionalized in a skilled nursing facility (SNF) or an

intermediate care facility (ICF). Such a program can include social services as well as respite care, short-term admissions at a sub-acute level. These waivers are available for states which establish packages of community based services as an alternative to institutional care, especially nursing home services.

According to HCFA officials a Section 2176 waiver application for AIDS patients would be acceptable under the following conditions:

> "One of the major requirements of a home and community-based services waiver is that the state demonstrate that the waiver program will be cost-effective as compared to the cost of institutionalization. Section 2176 waivers may be furnished to individuals who would otherwise require the level of care provided in a SNF or ICF and the required cost comparisons are normally made to the cost of these levels of nursing home care. However, it is clear that some individuals who are chronically ill, such as AIDS patients, remain in hospitals not because they require a hospital level of care but because, although requiring a SNF level of care, no SNF will accept them. As a result, HCFA has attempted to accommodate situations where the state indicates that hospitalized clients actually require SNF care. Such recipients may be included in a waiver program and the hospital costs of these individuals may be factored into the per capita expenditure estimate formula, thus facilitating a demonstration of waiver cost-effectiveness. In addition, although its impact on the AIDS population may be minimal, the recently passed Consolidated Omnibus Budget Reconciliation Act specifically authorized waiver services for individuals requiring a hospital level of care if they are ventilator dependent."

To develop a program on a smaller scale, a state might submit an application for a 2176 "model waiver." Model waivers can provide service packages directed at certain groups of Medicaid-eligibles such as AIDS patients. However, the size of the recipient groups is limited to 50 people. This may be an appropriate size in some states but not others.

Medicaid Freedom of Choice Waivers

In general, freedom of choice waivers focus on one or more categories of persons receiving assistance in the Medicaid population, or the entire Medicaid population in a specific geographic area. However, it would be possible to target a specific diagnosis population such as AIDS patients, provided that these patients were eligible under regular Medicaid standards.

Freedom of choice waivers were designed to provide more flexibility and encourage greater efficiency by states in the administration of their Medicaid programs. Under the provisions of Section 1915(b), the Secretary of the Department of Health and Human Services may, to the extent he finds it cost effective and efficient, and not inconsistent with the purposes of Title XIX, waiver any Medicaid State plan requirement found in Section 1902 of the Act, including the freedom of choice requirement, for four specific purposes. These purposes are: (1) to restrict recipients to primary care case-management systems or to specialty physician arrangements; (2) to allow localities to act as central brokers to assist recipients to choose among competing health plans; (3) to share with recipients, in the form of additional services, cost savings resulting from the use of more cost effective medical care; and (4) to restrict recipients to cost effective and efficient medical providers. A state must document in the waiver request, and maintain data regarding the cost effectiveness of the project, the effect on recipients regarding access to care and quality of services, and the projected impact of the program. Restrictions under the waiver may not apply to emergency services where medically necessary. When a state restricts providers, these providers must meet, accept, and comply with the state reimbursement, quality and utilization standards specified in the waiver request. In addition, the proposal may not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing the services.

A freedom of choice waiver could be constructed generally to restrict an AIDS patient to a primary care case manager who would locate, coordinate, and monitor all of his health care and who may also provide primary health care. This would provide AIDS patients with physicians to care for them while simultaneously linking the primary care to a network of other providers who have or will acquire experience in this area of treatment. This may be especially important for persons with AIDS, for a high-risk group, and for IV drug abusers. In addition, or standing on its own, a waiver could allow states to contract with the most cost effective and efficient providers for this population. This waiver can be applied to a broad variety of health providers, including physicians, hospitals, home health agencies, as well as to other providers of Medicaid services. However, as noted above, in order for the Secretary to grant a freedom of choice waiver, a state must present documentation that its proposal is cost effective. Given the lack of current

data concerning costs of treating Medicaid eligible AIDS patients, it may be difficult to document the cost effectiveness of proposals targeted to the AIDS population. Data originally available in a state's management and financial data systems may not contain enough specific information to be able to document what services to AIDS patients cost under the regular fee-for-service Medicaid program in a given state. Special surveys or in depth sampling of bills may be necessary to support a showing of cost effectiveness.

HCFA will consider only waiver requests submitted by or through the Governor. State cabinet members responsible for state Medicaid agency activities, the Director of the State Medicaid agency, or by someone with the authority to submit waiver requests on behalf of the director. Waiver requests are generally submitted by states to HCFA regional offices.

A number of states are attempting to accommodate AIDS patients in existing programs or expanding their programs to serve a broad group of patients with heavy care needs for which a hospital is not an appropriate setting. New York has a personal care program available to serve AIDS patients. Colorado has also examined possibilities for a home and community based waiver to provide services to AIDS patients among others. New Jersey has recently decided to reimburse independent laboratories for HTLV-III testing, and Tennessee is looking at similar coverage. Only Kansas currently includes hospice care under its 2176 waiver program for the aged and disabled and the mentally retarded populations. Other states are beginning to take AIDS patients into con- sideration as they work to finance and to maintain service packages adequate for the needs of their overall recipient populations.

Providers: Access and Reimbursement

Whether a state is or is not interested in developing options which would include services for AIDS patients, it must still find ways of securing access to care, conventional and otherwise. Medicaid beneficiaries can have difficulty finding available alternatives to hospital care, even where these are clearly more desirable. A serious complication is the reluctance of providers of nursing home and community based care to accept AIDS patients. These providers seem hesitant to take on these relatively high cost patients and the

possible risks associated with public fear of contagion. Nursing home placement has been especially difficult. As of February 1986, New Jersey had not successfully placed any AIDS recipients in nursing homes. Consequently, recipients remain in the hospital inpatient setting longer than they need to.

Some nursing homes are willing to admit AIDS patients in return for enhanced reimbursement, and a state might find that the cost of a supplementary payment is offset by reduced hospital expenditures. However, because of the Federal rule against discrimination by diagnosis, a supplement cannot be paid simply because a patient has AIDS. Instead, the reimbursement must be related to some defined additional service which can be rendered, not only to AIDS patients, but also to others with similar needs. New Jersey is seeking funding from its legislature to allow the state to offer such a supplement for post-hospital care. Florida has already developed a supplement to compensate nursing homes for extra costs of isolation and heavy care for AIDS patients and has had some success in placing patients. Michigan, which has no available space in nursing homes, is looking into the conversion of unused hospital beds into reserved long-term care beds for AIDS patients.

It should be noted that reimbursement changes may not solve all placement problems. Some facilities are simply not equipped to care for AIDS patients. For others, concerns about loss of patients, liability, and staff reluctance outweigh the compensation provided by increased reimbursement. In working with providers, states may find it helpful to review "AIDS and the Nursing Home Patient" prepared for the American Health Care Association and the National Foundation for Long Term Care and available from those organizations. In the future, additional problems may arise in obtaining proper care for patients suffering from the organic psychosis recently identified as a possible by-product of AIDS.

Conclusion

Much remains to be learned about the issue of financing the cost of health care for AIDS patients. At this time, important policy questions are beginning to surface, particularly in states with the most cases, but answers to

these questions are not readily apparent. Since the number of cases will continue to increase, the costs of care for these patients could have a considerable impact on state budgets and on the Medicaid program as a whole. Assessing that impact is important if states expect to plan for meeting the needs of Medicaid recipients with AIDS.

A number of options are open to states. Current programs may be adequate, perhaps with some modifications, or alternative delivery systems may be appropriate. New federal policies may provide choices involving optional services as well as waiver programs to include AIDS patients.

State policymakers are in a position to choose among these options according to the needs of a state population and the resources available. Certainly their responses will differ, just as the numbers of AIDS patients differ. Over time, as more information becomes available about the disease itself, the extent of its impact, the treatment needs of patients, and the costs of meeting these needs, states will have the opportunity to develop policies addressing the health care needs of those who suffer from AIDS.

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